PUBLIC HEALTH, WELFARE & SAFETY

Exhibit No. 1

Date 2-19-07

Bill No. SB 417

MHA

AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Testimony on SB 417
Before the Senate Public Health, Welfare and Safety Committee

By Bob Olsen, Vice President, MHA
February 19, 2007

Senate Bill 417 proposes to extend for two years the existing moratorium on licensing specialty hospitals. This bill presents Montana an opportunity to pause and consider the impacts that specialty hospitals have on access to care, health care costs, provider competition and the quality of services provided by all hospitals.

Public policy in Montana pertaining to specialty hospitals and other niche providers will have a fundamental and lasting affect on health care services. The moratorium is a reasonable way to make sure that no existing facility is prevented from providing services while public policy is established.

The provisions of SB 417 include:

- A state definition of what a specialty hospital is, and what it is not;
- Language to provide administrative guidance to the Department of Public Health and Human Services;
- A two-year extension of the current moratorium;
- Language to clarify that an existing health care facility can not become a specialty hospital; and
- The bill does not apply to hospitals, or specialty hospitals that now exist.

Section 1. This section takes up all but the last page of the bill. There are no amendments to the current statute for the first 6 pages of the bill. Beginning on page 7 line 30, SB 417 provides a definition of a specialty hospital. This language is necessary because the definition used in the current statute relies on a definition in federal law. That federal law has expired.

> The federal definition read: "1877(h)(7)(A) For purposes of this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital that is primarily or exclusively engaged in the care and treatment of one of the following categories:
>
> 1877(h)(7)(A)(i) Patients with a cardiac condition.
>
> 1877(h)(7)(A)(ii) Patients with an orthopedic condition.

1877(h)(7)(A)(iii) Patients receiving a surgical procedure.

1877(h)(7)(A)(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

MHA intends to follow the federal pattern. We are also providing a workable definition to serve the Department of Public Health and Human Services concerns about the licensing process. We differ from the federal definition in two ways. First we provide a measure for the Department to use to determine whether a facility is, or is not, a specialty hospital. Second, we list the kinds of facilities that are not subject to the moratorium.

SB 417, beginning **on line 2 of page 8, lists the categories of hospitals that are to be considered to be specialty hospitals**, and thus subject to the moratorium. The list includes cardiac, orthopedic, surgical and cancer hospitals. The Department, as was the Secretary of the federal agency under federal law, is authorized to designate other types of hospitals that offer specialized services.

Subpart b of the bill, beginning on line 8, provides guidance to the Department about how to make a determination whether a hospital is a general acute care hospital, a specialty hospital or a hospital exempt from the moratorium. This guidance is in the form of allowing up to 35% of the hospital services to be in areas other than the specialty services. A hospital whose services fall within this guideline may be determined to be a specialty hospital. If more than 35% of the services fall into other areas of care the hospital can be determined to be a general acute care facility.

Subpart c, beginning on line 11, provides a list of exemptions from the definition of a specialty hospital. The hospitals on this list are not typically established to compete directly with a general acute care hospital and are typically providing services that are more dependent on Medicare, Medicaid and other government programs.

Beginning on line 22 of page 8 and ending on line 10 of page 15 the bill strikes out old language in the statute. This strikeout does not amend the current statutes, it is merely housekeeping.

The Department proposes to amend MCA 50-5-203 to add language to guide the Department's process when issuing a license to a specialty hospital. The language is needed to provide the administrative process in which to address disputes, and avoid involving the courts.

Section 2. SB 417 amends MCA 50-5-245 by striking out the expired federal definition of a specialty hospital, **and extending the moratorium period until July 1, 2009.**

Section 4. SB 417 specifies that this bill does not allow a health care facility that currently exists to become a specialty hospital. That is, the bill **prohibits an ambulatory surgical center from becoming a hospital during the moratorium.** Other health care

facilities affected by the language include home health agencies, hospices, imaging centers and chemical dependency centers from converting to a specialty hospital.

Section 5 provides an effective date.

Section 6. The moratorium does not apply to any hospital that exists prior to the adoption of this statute. This means that the problem that occurred in Great Falls, in which Benefis and the Central Montana Hospital ended up in a hotly contested interpretation of the statute, won't happen again. The Montana Supreme Court, in its deliberations, noted that they believed the existing state statute was vague on this point. The moratorium simply does not apply to an existing hospital. The bill only applies to a new hospital.

MHA urges your support for SB 417.

MHA

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What are Specialty Hospitals?

- Specialty hospitals – or limited service providers as they are also called – focus on specific treatment procedures and conditions – e.g. heart, orthopedic surgical services and cancer treatment.
- SB 417 focuses on specialty hospitals. However, there also are a number of other outpatient specialty health care facilities, including ambulatory surgery centers, imaging centers and birthing centers.
- Specialty hospitals typically are for-profit facilities owned by physicians or large for-profit corporations.
- Commonly, they do not provide emergency department services and other services that are not profitable.

Legislative History

- In recognition of the proliferation of specialty hospitals, Congress in 2003, in the Medicare Modernization Act, imposed a moratorium on physician self-referral of Medicare and Medicaid patients to new limited-service hospitals. This moratorium expired in 2005, however, due to federal regulatory and statutory actions, in effect, it continued until August 2006.
- The federal moratorium defined specialty hospitals as facilities that primarily perform orthopedic, surgical, cardiac and cancer treatment procedures.
- During the interim, Congress directed the Medicare Payment Advisory Commission and the Centers for Medicare & Medicaid Services to conduct studies to determine the impact of specialty hospitals in the health care delivery system and to identify appropriate public policies.
- In Montana, legislation sponsored by Sen. Dan Harrington was enacted in 2005 to impose a moratorium on licensure of new specialty hospitals. The moratorium expires July 1, 2007. This legislation was designed to give Congress more time to determine public policy in this area.
- Congress continues to wrestle with this issue.

Specialty Hospitals have Adversely Affected Physician-Hospital Relations

- Physicians are the backbone of hospitals. Hospital administrators and boards of trustees do not admit patients or perform procedures – physicians do. For this reason, it is essential that hospitals and physicians work together for the benefit of patients.
- The rise of specialty hospitals and other limited service providers has severely strained physician-hospital relations.
- The threats posed by the increase in the number of limited service providers have forced hospitals to seek legislative assistance through an extension of the state moratorium.

Specialty Hospitals Can Cause Great Harm

- Limited service hospitals can cause great financial harm to full-service hospitals and the health care safety net.
- Why? Evidence is mounting that specialty hospitals accept patients who are well-insured for procedures that pay well. This takes away revenue that full-service hospitals need to offset the care they provide uninsured and charity care patients who require procedures that don't pay well.
- The effect of this "cherry-picking," is to weaken the health care safety net.

Physician Ownership Presents a Major Public Policy Issue

- Physicians have a financial incentive to refer patients to facilities that they own, which raises conflict-of-interest issues.
- Federal legislation ("Stark laws") in the late 1980's prohibited physician self-referral in certain circumstances, but did not address specialty hospitals.
- The rise of specialty hospitals has sparked proposals to ban all physician self-referral.

Specialty Hospitals & Competition

- Competition on a level playing field between full-service and limited-service hospitals can benefit the patients, communities and regions we serve.
- Unfair competition weakens the health care safety net provided by non-profit, community-based hospitals.

Growth of Niche Providers Drives Costs

- The proliferation of specialty hospitals and providers of niche services drives up health care costs by creating new capacity in the health care delivery system.
- It is important to balance the cost of duplicating health care services within a community with the additional consumer choice that is provided.

Specialty Hospitals Remain a Major Issue in Congress

- The federal moratorium has expired.
- The Centers for Medicare & Medicaid Services (CMS) has implemented reimbursement changes in an effort to remove the financial incentives that encourage physicians to refer patients to facilities that they own.
- However, it will take some time to determine if this effort will effectively level the playing field.
- Congress has renewed efforts to halt development of specialty hospitals and restrict physician self-referral.
- For these reasons, an extension of the state moratorium is needed to give Congress time to finish its work.

SB 417 Would Extend the State Moratorium

- SB 417 would extend the moratorium until July 1, 2009.
- This would give additional time for Congress to fashion a nationwide solution to this issue.
- This bill also would give the Department of Public Health and Human Services direction in developing rules to implement this statute.

Ending the Moratorium Would Lead to Proliferation of New Specialty Hospitals

- In communities in which there is no moratorium has experienced the significant negative effects of the development of specialty hospitals.

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American Hospital Association

The Health Care Market Must Protect Against Conflict of Interest: Talking Points

Fair competition is the hallmark of our country's free market system. To ensure fair competition, rules and regulations are in place to make sure conflicts of interest do not interfere with market forces. We see this everyday with the stock market, where brokers are banned from hyping a stock in which they have an ownership stake. We also see it in rules prohibiting insider trading.

And yet a physician, under the guise of "free market competition" can refer carefully selected patients to a limited service hospital the physician owns for personal gain. Physician self-referral is anti-competitive and we ask whether those who seek to retain conflict of interest policies have as their "bottom line" what's right for patients and communities?

For America's full-service community hospitals, the real bottom line is our top priority: getting people the right care, at the right time, in the right place. Does physician self-referral to limited-service hospitals have that same bottom line at heart? Let's look at the facts:

- Physician self-referral allows physician-owners to profit by referring carefully selected patients to the facilities in which they have an interest. Economically unattractive patients are avoided or sent to the community hospitals.

- **The Medicare Payment Advisory Commission (MedPAC) has found that limited-service hospitals treat far fewer Medicaid recipients** than community hospitals in the same market – 75 percent fewer for physician-owned heart hospitals and 94 percent fewer for orthopedic hospitals. The General Accountability Office (GAO) reports similar results.

- **According to MedPAC, limited-service hospitals concentrate on services that bring the highest profits, and treat patients with the least-complex cases.** This leaves the more complex, lower-reimbursement patients to full-service community hospitals. The GAO also found that limited-service hospitals serve patients who are less sick.

- Studies by O'Melveny & Myers LLP and KPMG found that:

    - **The rate of return on investment by physicians in limited service hospitals are extraordinary**, with physicians making at least three to five times their original investment in a short period of time;

(over)

- **Interests in the limited service facility are offered solely to those physicians in a position to refer to the facility;**
- Shares or interests are offered to physicians at prices heavily discounted below fair market value;
- The risks physician investors are taking in exchange for these returns is minimal; and,
- **Physicians are responding to these returns by referring, almost from day one of their investment, their profitable business to the facility in which they have an investment interest.**

- Competition in healthcare should provide greater efficiencies and bring costs down. However, **MedPAC found that physician owned limited service hospitals <u>do NOT have lower costs</u> than full service hospitals—raising serious questions about whether they are in fact "more efficient " or "lower cost."**

Full-service community hospitals welcome competition from limited service hospitals and others —they compete successfully everyday in communities across the country based on quality, price, and services. The issue is not competition, but rather the blatant conflict of interest that exists when a physician is an owner of a limited service hospital <u>and</u> controls patient referrals.

Competition is supposed to be about consumer choice. As currently structured, this system is all about physician-owner choice – not patient choice. And, it leads to manipulation of the Medicare payment system for personal gain. It is not fair and open competition, it is egregious anticompetitive behavior. And it leads to decisions being made not in the best interests of a patient, but rather on the financial interests of the doctor.

To be clear, the existence of limited-service hospitals in the marketplace is not the issue nor is there an issue with physicians having ownership in a hospital to which they do not refer—it is the combination of ownership and self-referral that is anticompetitive at its core.

The solution is clear: Ensure a fair health care marketplace, eliminate conflict of interest, and ban, permanently, physician self-referral to new limited-service hospitals.

Cover Story » *Jessica Zigmond*

BETTING BIG ON DOC OWNERSHIP

'Boutique' chain blasts off with $1 billion investment, plans for 10 hospitals, and hopes to create healthcare model of the future

Former stockbroker Kamran Nezami and his physician partners believe their business plan for physician-owned hospitals is the healthcare model of the future, and a North Carolina development company is betting $1 billion that they're right.

Although the physician ownership concept is not new, the agreement between Nezami's University General Hospital Systems in Houston and Charlotte, N.C.-based Alliance Development Group is unique not only for its size, but also because it involves many of healthcare's hottest issues. Patient care, payer mix, physician financial interest, managed-care network contracts, and the ongoing struggle between small, "boutique" facilities and their large community hospital counterparts—this deal has it all.

In the $1 billion transaction—which the two companies signed Nov. 30 and announced the next day—Alliance will work with UGHS to build 10 physician-owned, general acute-care hospitals in various markets nationwide. Alliance will handle the real estate and lease the facilities to UGHS, which will manage and operate the approximately 80-bed hospitals. The companies expect to break ground on a facility in Houston's Chinatown area in the first quarter of 2007, and plan to begin building a new facility every three months, Nezami said. In addition to Houston, he listed Dallas, Denver and Phoenix as some of the sites, and said other markets would be announced later.

All of the markets are in states without certificate-of-need laws except for one, Nezami said. W.J. "Bill" Burk, president and chief executive officer at Alliance, identified Hawaii (which has a CON program) as another site, and there could be additional projects, but 10 is an appropriate number for now. Nezami said UGHS would like to build in Hawaii, but it would be a "tough battle" because it's a CON state.

The project is likely to attract a lot of attention with so many eyes already focused on the specialty hospital industry, and acute-care hospital executives making a case with Congress to limit physicians in their ownership of hospitals.

"For us, the issue all along has been physician ownership and self-referral," said Carmela Coyle, senior vice president for policy at the American Hospital Association. "It is less (about) limited service. The concern is whether the physicians are acting in the best interest of the patients or their own financial interest."

But the outcry over specialty hospitals and physician ownership hasn't deterred Nezami and his partners from the project, the roots of which go back more than a decade.

As a stockbroker with Merrill Lynch & Co. in the mid-'90s, Nezami said he had physician clients and understood that baby boomers would be putting their money into healthcare. Originally, Nezami had planned to develop an ambulatory surgery center until physician partner Hassan Chahadeh said they should build a hospital. "What happens with these major hospital systems is there is a huge bureaucracy. Things rarely get done. Nobody (is) motivated to make decisions or any changes," Nezami said. University General Hospital Systems has set out to fix that, and Nezami said he thinks the model will change the face of healthcare in America.

The company began in May 2005, when Nezami and physicians Chahadeh, Octavio Calvillo, Henry Small and Felix Spiegel formed University Hospital Systems, a private, for-profit company that developed University General Hospital—a 72-bed Houston facility that opened in September and was granted accreditation by the Joint Commission Accreditation of Healthcare Organizations, effective Dec. 1.

About 70 physicians are limited partners and own about 65% of the facility, or roughly 1% each, while Nezami, Chahadeh, Calvillo, Small and Spiegel are general partners and own the remaining 35% interest. The company later formed University General Hospital System which will oversee the future projects and have

THE TWO PARTNERS

A snapshot of the two companies that are joining together in a $1 billion plan to create a chain of 10 smaller acute-care facilities.

University General Hospital Systems

Kamran Nezami, president and CEO

Private, for-profit healthcare company

Established in 2006

Revenue: Declined to provide

Employees: 15

Alliance Development Group

W.J. "Bill" Burk, president and CEO

Private real estate services company in healthcare, casual dining, banking

Established in 2004

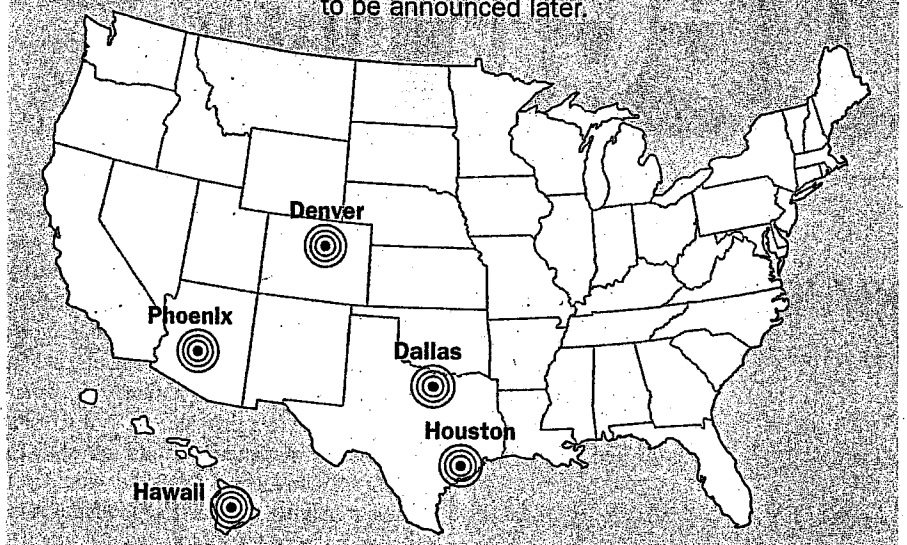
Revenue: Declined to provide

Employees: 20 (estimated)

Sources: University General Hospital Systems, Alliance Development Group

TARGET MARKETS

University General Hospital Systems and Alliance Development Group are planning to expand their chain of physician-owned, acute-care hospitals in the following areas, with other markets to be announced later.



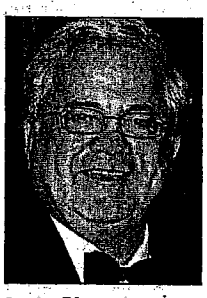
Sources: University General Hospital Systems, Alliance Development Group

a similar ownership breakdown. UGHS includes the same general partners except for Calvillo, Nezami said.

Some practitioners agree with Nezami that physician ownership is an effective model. Robert Davis, a limited partner and general surgeon who works at both University General Hospital and 911-bed Methodist Hospital in Houston is among those. Davis, who has been a physician for 30 years, said physician groups have left Methodist because they don't see "eye-to-eye" with administrators on care.

"There is nothing wrong with Methodist," Davis said. "But there is a very deep bureaucracy. ... If you want to get an instrument you need, the layer may be 20-30 layers deep, whereas in the new hospital, we get it tomorrow. ... We can also control our expenditures. We doctors own the hospital."

Methodist executives weren't available for comment. Representatives for St. Luke's Episcopal Health System and 711-bed Memorial Hermann Hospital, located close to University General Hospital in Houston, also were not available for comment.



Davis: Big systems are weighed down by bureaucracy.

Similar to the flagship, University General Hospital, the new facilities will have the "look and feel of a Four Seasons hotel," but will provide full services, and accept any patient who walks through the door, Nezami said. They will also have strong bariatric and orthopedic components, but aren't specialty hospitals, he said.

Nezami said the real criticism from opponents is whether these hospitals care for the underinsured and uninsured. "Do we target the indigent population? No. Can we handle anyone who walks through our doors? Yes."

A Congressional Budget Office report released last week found one area where the for-profit industry serves the poor better than the not-for-profit industry (See story, p. 12).

Laura Comer, director of managed care at University General Hospital, said the hospital expects to receive its Medicare license within the month. The hospital must wait for its Medicare license before it applies for Medicaid.

One of University General Hospital's goals is to be an in-network provider, which has been proven to be a challenge. Comer said big players Aetna, Humana and UniCare have all denied University General Hospital access to their networks, and local competitors don't want the hospital in the networks for fear it might take away lucrative business.

A similar struggle happened in Kansas last year, when physician-owned Heartland Spine & Specialty Hospital in Overland Park filed suit against several hospitals and insurers for allegedly excluding 19-bed Heartland from obtaining in-network contracts (May 9, 2005, p. 6). Now in the discovery stage, the case is set for trial in April 2008, according to an attorney for Heartland.

Jared Wolfe, executive director of the Texas Association of Health Plans, acknowledged that

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CHAINS >> *Vince Galloro*

'Stealth' chains lure big bucks

Small, nimble for-profit companies such as University General Hospital Systems threaten to take away the best-paying patients of established hospitals in high-growth markets that lack certificate-of-need protection, according to a new report by Moody's Investors Service.

These "stealth" companies are owned by private investors rather than through public stock ownership, so they don't have to disclose much about their strategies or deals, making it tougher for competitors to react, said Lisa Goldstein, a senior vice president and manager at Moody's.

The warning from Moody's came as Fitch Ratings said last week that it expects bad debt to continue to be a problem for investor-owned hospital companies in 2007. That problem will largely be offset by continued strength in commercial and Medicare reimbursements and the generally strong cash flow of the hospital business, Fitch said. Fitch also said it expects shareholders will increase their pressure on the companies, possibly leading to more going-private transactions like the recent leveraged buyout of HCA.

Besides University General, some other "stealth" companies cited by Goldstein include: GP Medical Ventures, Nashville, which recently won the bidding for 288-bed Carraway Methodist Medical Center, Birmingham, Ala., for $26.5 million (Nov. 13, p. 4); Rockwall Hospitals, Richardson, Texas, which has projects in four Texas cities, including Houston and Austin; and Surgical Development Partners, Brentwood, Tenn., which has two hospital projects in Houston and one in Murrieta, Calif.

They typically build their hospitals close to established acute-care hospitals and then seek to win over well-insured patients with greater amenities, Goldstein said. Their brand-new facilities have all private rooms and perks that may include Internet access, shorter wait times and valet parking, she said. Houston is the most advanced market for these new hospitals, with several projects going forward or ready to open, Goldstein said. Arizona and Nevada are two other states that would fit the profile for these new companies, she added.

Besides hospitals, many of these

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this is a legitimate concern: "I've been told of cases in Houston in which hospitals have threatened to drop health plans based on whether or not they decide to contract with other hospitals in the area."

An Aetna spokeswoman confirmed that University General Hospital is not in network but did not elaborate on why; a Humana spokesman said in a written statement that Humana considers "the topic of network contracts to be proprietary and confidential," and a spokeswoman for UniCare said while it is true that University General is not in the carrier's network, the company could not comment on the specific case.

Blue Cross and Blue Shield of Texas agreed to an indemnity insurance contract with University General Hospital for 55,000 lives pending the hospital's certification, according to a Blues spokeswoman.

Nezami said the business plan was set up to prepare for potential payer problems. "You have to have the right volume," Nezami said. "You have to find the busiest physicians to sustain the volume you need to survive, because you can't have all patients out of network."

This raises the question of payer mix. Patients who can afford services at an upscale facility such as University General Hospital benefit, while questions linger about those who cannot pay.

"The community hospital complaint is that the physicians are very selective in the patients they are treating," said Charles Bailey, spokesman for the Texas Hospital Association, of which University General is a member. "They are less acute and potentially more profitable."

These concerns mirror the arguments in the physician-owned specialty hospital debate, which culminated in August with the end of a federal moratorium on such facilities. Bailey said it is not surprising that some companies developing physician-owned hospitals will broaden their services so they do not fall under the specialty hospital definition.

At the state level, the Idaho Board of Health and Welfare voted last week to deny a petition from the Idaho Hospital Association to temporarily suspend applications for new hospital beds. According to Steve Millard, president of the hospital association, the group filed the petition after it learned of plans for a physician-owned specialty hospital in southwestern Idaho. The measure would have affected all hospitals, including some of the association's members, Millard said. The hospital association plans to continue the fight against specialty-hospital development next month when it petitions the state Legislature to make Idaho a CON state.

In Arizona, where UGHS plans to build, the Arizona Hospital and Healthcare Association agreed that the core of the issue is physician self-referral and that Congress should address the issue. But John Rivers, the association's president and CEO, also noted that 225,000 peop have moved to the region in the past 12 month and that nearly all hospitals are operating a capacity. Rivers said the association takes issu with hospitals that may not have an emergenc department or an emergency physician on staf

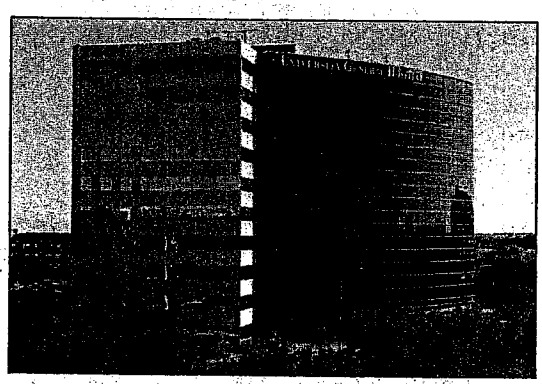
Sharon McDonough, vice president c operations and chief nursing officer at Univer sity General Hospital, which is near the Texa Medical center, said its emergency departmer has a unit secretary, two registered nurse and a physician on staff at all times, an that the new system's facilities will follow similar model.

"They are generally welcome as long a they are playing by the same rules as every one else, and it sounds like UGHS is not model that would be troublesome to us a all," Rivers said. Rivers also cited the Med Cath model as one that has been controver sial to some, but not to the association.

MedCath Corp. owns a 51% stake i its Arizona Heart Hospital, with physi cians owning the remaining 49% Licensed as an acute-care hospital, th 59-bed facility provides all services including an emergency room, even thoug most of its business is in heart care.

MedCath's hospitals are licensed as genera acute-care facilities with a focus on patient who have cardiovascular disease. The compa ny's model is to "bridge the gap between th practice of medicine and the business of med icine" by partnering with cardiology physi cians, according to the company's Web site. Ec French, president and CEO of MedCath, saic the company's hospitals are unique because o their physician joint ownership and strong core of heart services.

As the various players push their own agendas, there is still ambiguity about how to distinguish a specialty hospital from a general acute-care hospital. The AHA's Coyle said she is hopeful the new Congress will be more favorable to addressing the issues of physician ownership and self-referral. Rep. Pete Stark of California, the ranking Democrat on the House Ways and Means Health Subcommittee and longtime opponent of physician ownership, offered a written statement on the topic: "For years, I've been concerned that physician-owned hospitals are pulling profit centers out of community hospitals. In the next Congress, I hope to work with colleagues on both sides of the aisle to stop their proliferation." «



The Houston flagship and UGHS' other outposts will have the "look and feel of a Four Seasons hotel."

STEALTH » from p. 7

companies also develop outpatient surgery and imaging centers.

They represent a much different challenge than the specialty hospitals with physician investors that were stymied by a moratorium on their construction that began in 2003 and ended this year, Goldstein said. Unlike those hospitals, these are general acute-care hospitals, with emergency and general surgery departments and treatment of "bruises, bumps and lumps," she said.

Like specialty hospitals, these new hospitals often include physician investors, Goldstein added, but with a twist: They're primary-care physicians instead of specialists and surgeons. Primary-care physicians control referrals to specialists and surgeons and can influence—although not induce explicitly—where the specialists and surgeons practice on patients referred to them, she said.

Whether this competitive threat has staying power "will be a function of whether these providers can get managed-care contracts," Goldstein said. "They're not in it for the Medicare/Medicaid population, and they can only live so long on out-of-network patients." «

What do you think?

Write us with your comments. Via e-mail, it's mhletters@crain.com; by fax, 312-280-3183.

TIME
FROM THE MAGAZINE
Tuesday, Dec. 5, 2006

The Hospital Wars

Surgery and imaging centers owned by doctors are swiping patients from traditional hospitals. Competition is good, right? Not always in health care, where an arms race keeps the costs rising

By UNMESH KHER/WICHITA

Kevin Conlin has a problem. Physicians in Wichita have been catching a bug. An entrepreneurial bug. One that compels them to build highly specialized hospitals, diagnostic imaging facilities stocked with next-generation scanners, and same-day surgery centers that have hotel-like touches. Conlin, CEO of the $1.2 billion nonprofit Via Christi Health System in Kansas, complains that these outfits are competing unfairly against St. Francis and St. Joseph, his two general hospitals in Wichita. And he intends to do something about it. Via Christi provided Kansans with some $30 million in charity care and $33 million in unpaid Medicaid services this year. Conlin says Via Christi can no longer afford those costs if it keeps losing money to the new guys. "We're left with no option," says Conlin, "but to set a limit on how much of this kind of work we're going to do. Only then will we have a public conversation about the issues this phenomenon raises."

That phenomenon has sparked a war between hospitals and doctors across the country that is transforming the landscape of the U.S. health-care system--while not necessarily improving it. Hospital bosses say doctors, who wield huge influence over their patients, steer the most profitable procedures to facilities they own and shunt the least lucrative ones to the general hospital. This threatens the ability of the general hospital to provide money-losing services like emergency care, which it subsidizes in part with profits from procedures like cardiac surgery. The specialty competitors deny that they are the problem. Quite the opposite. "We raise the bar for the community," says Ed French, CEO of MedCath, which runs 12 specialty hospitals. "Everybody invests in more equipment and focuses more on nursing care because we set the competitive standard."

But researchers led by Paul Ginsburg at the Center for Studying Health System Change (HSC) in Washington find that this standard is fueling a de facto medical arms race, a competition that, perversely, increases health-care costs. Competition is not supposed to do that, but in the topsy-turvy

U.S. health economy, excess supply often induces demand.

Hospital executives are responding to the assault of specialists by building and aggressively marketing profitable "service lines," like cancer, heart and brain centers. They're snapping up $1.4 million computed tomography (CT) scanners, which produce palpably detailed, 3-D pictures of bones and organs, and $2.2 million "high field" MRI machines that can watch the brain at work. The inflationary dynamic spawned by this expansion of health-care capacity exposes flaws in the payment system that sustains U.S. health care. Those flaws partly explain why Americans spend $2 trillion, or 16% of their GDP, for medical care, an outlay that's increasing roughly 7% annually.

There are only about 130 specialty hospitals in the U.S., compared with some 5,000 community hospitals, but dozens more are in the works since Congress this summer lifted a three-year moratorium on Medicare payments to new specialty hospitals. These typically focus on orthopedic and cardiac surgeries--which account for more than half the profits of many hospitals--and most lack costly emergency rooms. As these and other doctor-owned facilities spread and tensions soar, hospitals are finding it harder to get specialists on call in their ERs, reports HSC researcher Dr. Robert Berenson in a study published on the Web this week by Health Affairs.

Ambulatory Surgery Centers (ASCs), which compete with hospital outpatient departments for procedures that don't require overnight stays, like colonoscopies and some joint surgeries, are hollowing out hospitals as well. There are almost 5,000 ASCs today, nearly twice as many as a decade ago. Four in five are at least partly owned by physicians, many in partnership with hospitals seeking to minimize losses. The number of imaging centers has climbed to 6,037, up from 4,159 in 2001, according to the data firm Verispan. The scanning machines are costly to maintain, but once those costs are covered, the machines mint money. "There's an intense market-share competition taking place between hospital outpatient departments and imaging centers," says John Donahue, chairman of National Imaging Associates, which manages radiology for insurers in 36 states. "This battle is under way in Florida, Texas and virtually every state in which we operate."

Wichitans have had front- row seats to the war. In 1997, disgruntled cardiologists led by Dr. Gregory Duick approached Via Christi about establishing a heart hospital. "There was no grand conspiracy to make more dollars for doctors," says Duick. "It was fanned by frustration with the hospitals' inability to get things done and a lack of input from physicians on administration." When Via Christi declined, the doctors tapped local investors, and in 1999 opened the smartly designed, one-story Kansas Heart Hospital in a tony northeastern quadrant of town.

Kansas Heart triggered a cascade. This quiet, airy city of 540,000 already had--besides Via Christi's hospitals--the Wesley Medical Center, part of the for-profit HCA chain. Wichita now has five doctor-owned hospitals as

well, along with a dozen ASCs and at least 10 free-standing diagnostic imaging centers, eight of which have physician investors. (Via Christi has a share in four of them, as it does in one ASC and a specialty hospital.) "The fear that emergency rooms and cardiovascular programs would close at community hospitals," says Duick, "has not been borne out over seven years in Wichita."

Money isn't the only motivator. Entrepreneurial physicians say they're tired of waiting for inefficiently scheduled hospital ORs to open up, that they're more productive and have better nursing support at their own facilities. Scott Barlow, CEO of the Central Utah Clinic in Provo, which runs an ASC, says that until the clinic bought its own imaging machines, patients had to wait up to 24 days to get a diagnostic scan at the nearby hospital. "This is about convenience, lower cost and higher quality," says Glen Tullman, CEO of Allscripts, an electronic-medical-records firm that works with ASCs and specialty hospitals. "Nobody in health care wants to be on the wrong side of that equation."

But is the competition fair? Within two years after Galichia Heart Hospital opened in Wichita in 2001, Wesley's net revenues from its cardiovascular program plummeted from a notch above $18 million to roughly $2 million. In 2003 the Kansas Spine Hospital opened, and in a year Wesley's neurosurgery revenues dropped $8.8 million, to roughly $1 million. Via Christi cardiovascular surgeries declined from 4,334 in 1998 to an estimated 2,950 this year. In that period, its executives say, the number of nonsurgically treated cardiac patients--who, say, have heart failure--remained relatively steady, around 4,300.

This matters, as Medicare reimburses most surgeries above the cost of care and nonsurgical treatments at lower rates, sometimes below cost. Hospitals make up the losses--and those from treating the uninsured--largely with profits from surgeries. They also hike the prices they charge insurers and employers, who give hospitals a 22% margin, according to researchers at the Lewin Group, a consultancy, helping cover overall losses of 5% or more from Medicare and Medicaid. That comes back to the rest of us as higher insurance premiums, making health care all the more costly to employers.

Physician-owned facilities do less charity care and treat fewer Medicaid patients than community hospitals do, government research shows. And they treat healthier (hence more profitable) patients, or--as in the case of heart hospitals--favor well-remunerated treatments. Not surprisingly, doctors who own a piece of the action are more likely to send patients to their own facilities.

The shift of patients can be devastating. Regionally owned Lincoln General Hospital in Ruston, La., lost about $2.5 million in business a year to imaging centers and an ASC, but was managing to stay afloat, according to CEO Tom Stone. Then, in 2003, the 40 physicians who ran the ASC opened the Green Clinic Surgical Hospital. Lincoln's inpatient and ambulatory surgeries halved, and by 2005 the hospital was $8 million in the

red. "They've gone beyond cherry-picking," says Stone. "They've removed virtually everything they could take out of this facility." He is selling the hospital to a for-profit chain.

Green Clinic's CEO, Robert Goodwill, says Lincoln just screwed up. Its board declined an offer to invest in the specialty hospital, he says, and the hospital's losses stem from a "spending binge" Stone began in his attempt to compete. "Patients are choosing us because we're vastly superior," Goodwill says. But hospital bosses say this choice isn't a real one. "You're not going to disagree with the guy who's going to be cuttin' on you," says John Goodnow, CEO of Benefis Healthcare, a hospital system in Great Falls, Mont., that tried unsuccessfully to shut down a specialty hospital opened by half the city's doctors. "You can say patients have choice. Yes, theoretically. But c'mon, who's going to go against their own physician?"

Hospitals are fighting back in none-too-subtle ways. Some won't let an ASC physician-investor admit patients in their wards. And powerful health systems often use their leverage to lock physician-owned competitors out of preferred networks of insurers. Via Christi owns Kansas' largest managed-care plan; Wesley has an exclusive contract in Wichita with the state's leading insurer, Blue Cross and Blue Shield. "It's brutal competition," says David Laird, CEO of the Heart Hospital of Austin, which competes with the Texas nonprofit Seton Medical Center. "They act like they have a halo over their heads."

Such competition is fueling the arms race. Via Christi is counterattacking with a new neuromedicine service line. The weapons: a 64-slice CT scanner; and a brand-new $3.5 million CyberKnife, an X-ray gun that zaps tumors with pinpoint precision, housed in its own $1.5 million building. It has set up a stroke-treatment center and brain-aneurysm lab. "This is one of the areas that we've beefed up since all the specialty stuff happened," says Larry Schumacher, CEO of Via Christi's Wichita operations. "We're trying very hard to protect that." Wesley, for its part, has remodeled its operating rooms, opened a $54 million, four-story critical-care building and invested in its own gadgetry. "We compete on technology and have to stay state of the art," says Francie Ekengren, chief medical officer.

And if they build it, we'll fill it. The Medicare Payment Advisory Commission found that health-care markets with specialty hospitals have roughly 6% more cardiac surgeries and 9% more bypasses than markets without them. It's not that doctors deliberately push unnecessary surgery, but when a choice of treatments exists, capacity and monetary incentives have been known to influence the choices physicians make.

Nowhere is this more apparent than in diagnostic imaging. Last year Americans spent more than $100 billion on outpatient scans. Medicare's imaging costs have been growing 16% a year, much faster than the 9.6% rise for all physician services. The most lucrative--MRI and CT--climbed 25% last year. A third of the testing, says Donahue of National Imaging, is inappropriate; doctors order unnecessary scans, or two when one would suffice. "This is one of the most unsavory and concerning areas of how

imaging is delivered," he says. "It's when imaging studies are not based upon clinical needs but on entrepreneurial requirements." Much of the growth is coming from cardiologists and orthopedists, who increasingly own such devices. It angers radiologists, who rely on referrals, and even imaging-center executives. "There should be some relief on the physician self-referral problem," says Bret Jorgensen, CEO of the chain InSight Health. "It's the single biggest reason imaging centers have been growing so rapidly." Physicians say much of the supposedly excessive testing is defensive. "If you fail to do a test and there's a bad outcome," says Dr. Kim Allan Williams, a nuclear cardiologist at the University of Chicago, "you will get sued in this country."

Congress and the Centers for Medicare and Medicaid Services (CMS) have taken steps to rein in imaging. Beginning next year, imaging centers will see payment cuts that the industry and its manufacturing allies--GE, Siemens, Phillips--say will reduce some payments to 20% of the cost of doing them. To level the specialty-hospital playing field, CMS will pay hospitals more for their more complex cases. Similarly it proposes to pay ASCs at 62% the rate of hospital outpatient departments. The industry is asking for 75%. Lobbyists are racing to the scene.

Though these changes are probably a step in the right direction, they do not directly address the problem of physician self-referral--or the distorted economics that underpin the rise of specialty facilities. Next year Medicare will pay physicians more for the time they spend on their patients' well-being, but, HSC researcher Dr. Hoangmai Pham notes, it still rewards them far more generously for procedures than for cognitive services like diagnosis and management of disease. So Wichita, which 15 years ago had seven psychiatric inpatient facilities, now has one, run by Via Christi. It has six that do heart surgeries.

Further, since physicians get paid through fee-for-service rather than, say, for curing their patients, their primary incentive is to do more stuff. CMS is starting to experiment with pay-for-performance programs that address this concern. But such measures can work only if they are remunerative enough to counter the base incentives that drive excess care. "A few pennies here and there is not going to change what physicians do every day," says Pham. "They're not stupid, and they have business managers."

And political clout. As do the manufacturers of medical technology. So creating a payment system that makes competition work as it ought to--reducing costs rather than inflating them--won't be easy. But the same can be said for living in a society that can't afford its sick and dying.

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